

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40932**
Registrar's No. **4670**

FILED JAN 24 1943 77
Registration District No. **1002**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Jackson City**
(c) Name of hospital or institution **3411 Highland**
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution **60 days**
(Specify whether years, months or days) **60 Days**

3. (a) PRINT FULL NAME **ROWENA F. HUGHES**

3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

5. Color or race **Female White** 6. (a) Single, widowed, married **Widowed**
(b) Name of husband or wife **John P. Hughes** 6. (c) Age of husband or wife if alive **1855**
7. Birth date of deceased **July 1** (Month) (Day) (Year)

8. AGE: **86** Years **5** Months **10** Days If less than one day hr. min.

9. Birthplace **Coal Run Ohio** (City, town, or county) (State or foreign country)

10. Usual occupation **House work**

11. Industry or business

12. Name **John Roach**
13. Birthplace **Coal Run Ohio** (City, town, or county) (State or foreign country)
14. Maiden name **Rebecca Mason**
15. Birthplace **Coal Run Ohio** (City, town, or county) (State or foreign country)

16. (a) Informant **John P. Hughes**
(b) Address **Route one Independence Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12-13-41** (Month) (Day) (Year)

(c) Place: burial or cremation **Salem Cemetery**

18. (a) Signature of funeral director **George C. Carson**
(b) Address **Independence Mo**

19. (a) **Dec 12, 1941** (Date received local registrar) (b) **M. M. Crow** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Independence** (If outside city or town limits, write "RURAL") **048**
(d) Street No. **Route one** (If rural, give location) **0**
(e) Citizen of foreign country? **No** (Yes or No) **1**
If yes, name country **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **11** year **1941** hour **2** minute **P** M.

21. I hereby certify that I attended the deceased from **15** 19 **41** to **Dec 11** 19 **41**
that I last saw him alive on **Dec 11** 19 **41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia** Duration **7 days**

Due to **Myocardial Degeneration and Pulmonary Edema**
Due to **Senility**

Other conditions (Include pregnancy within 3 months of death) **107**

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) Means of injury

23. Signature **W. H. Thompson** (M. D. or other) **MD**
Address **3850 E 27th St, Eads** Date signed **12-11-41**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Raymond N. Martin

Licensed Embalmer No. *4150*

P. O. Address *Independence, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.